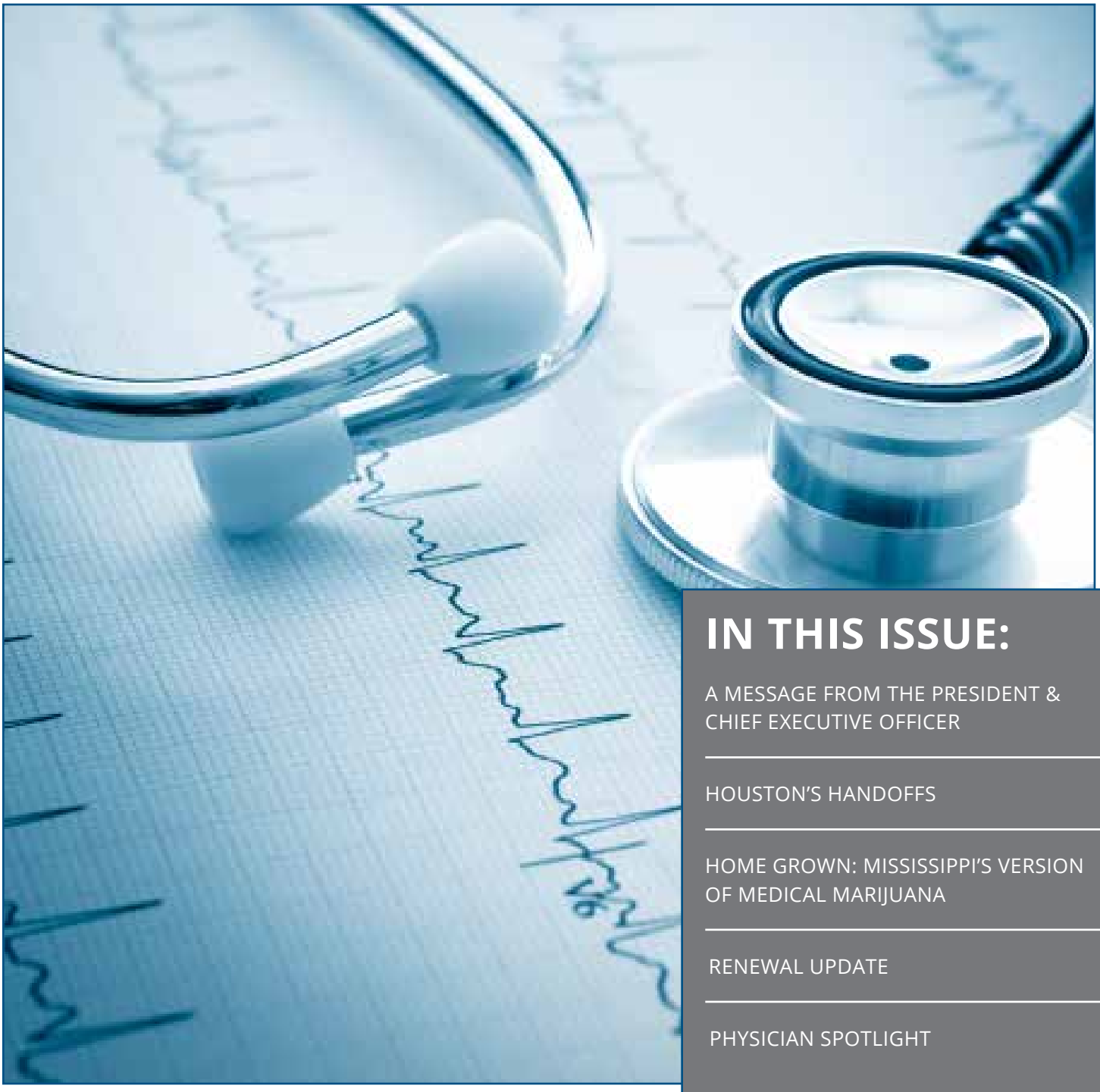
SUMMER 2022

THE MONITOR



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MACM®

A MESSAGE FROM THE PRESIDENT & CHIEF EXECUTIVE OFFICER

WHAT'S IN A NAME?

By: Robert M. Jones

Medical Assurance Company of Mississippi has been sending this publication to our insureds and friends for decades; however, why is it named the "***MACM Monitor***"? This name reflects the fact that the staff at MACM constantly monitors many things that relate to your medical practice and the medical professional liability insurance that protects you. Allow me to mention a few examples.

We monitor trends in claims. Using our experience in claims filed against our physicians and information available from several national sources, the Claims Department and General Counsel evaluate trends in the types, frequency and severity of claims. They also ensure that our defense attorneys are using the latest and most effective techniques when defending claims against MACM physicians.

We monitor risks in medical practices. Our Risk Management Department spends a great deal of time conducting surveys of insured physicians and their clinic staff by providing detailed reports and recommendations specific to the physician and clinic to improve their patient care and decrease liability risk. The risk managers also analyze MACM claims to identify issues relating to quality of care, communication, and documentation. Our Risk Managers take questions from MACM insureds and assist them in addressing difficult issues. They also review outside resources and attend seminars to understand current risk management issues facing MACM physicians so they can fashion the most effective risk management programs for our physicians, nurses, and clinics.

We monitor MACM's investments. Our Chief Financial Officer and Investment Committee, with the assistance of outside consultants and investment managers, constantly review the status, security and performance of MACM's investments. This ongoing effort ensures that the assets and surplus of the company are safe and your Equity Account is maximized.

We monitor legislation and political activity. Our Senior Management and Government Relations Committee follow the activities of the Mississippi Legislature and government agencies and maintain close relationships with the political leaders in Mississippi. We understand that laws and regulations directly affect your medical practice and our insurance company.

We monitor cyber threats. Our Information Technology Department closely monitors cyber activity and potential threats to MACM and our physicians. By constantly updating our defenses, we endeavor to protect the systems vital to providing services to you.

We monitor technology. MACM is constantly looking for new and better ways to protect you and provide services to you. Through the use of innovative technology such as our Members Only access to information, online renewal applications and digital insurance policies, MACM can expedite underwriting and reduce the cost of operations.

We monitor changes in the practice of medicine. As the practice of medicine constantly changes, MACM must change also; therefore, we are constantly reviewing and analyzing how changes in the practice of medicine affect MACM's positions in the way we insure you and your practice.

As we monitor many things that affect your medical practice and our ability to protect you, we hope you realize that MACM "has your back"! We consider it a privilege to be your partner in providing safe medical care in Mississippi.

HOUSTON'S HANDOFFS

CASE STUDY

FAILURE TO DIAGNOSE

By Gerry Ann Houston, MD, Medical Director

In August 2018, a 50-year-old female went for her first visit with a new OB/GYN. Though it had been 10 years since she had a pelvic exam and PAP, she reported no problems or concerns, and a routine PAP was done. The following January she saw her LMD with a 3-week history of heavy vaginal bleeding. She was referred back to the OB/GYN she had seen 5 months earlier. At that time, he reviewed her prior PAP report that showed "atypical squamous cells, cannot rule out high grade squamous intraepithelial lesion." The patient had not been notified of the abnormal PAP, and the OB/GYN said he "had inadvertently signed and closed" the report in the EMR and no follow up was done. On exam, the patient had a 1-2 cm mass in the lower uterine segment with ultrasound confirming the mass. Endocervical biopsy was invasive moderately differentiated adenocarcinoma. She subsequently had a TAH, BSO, and pelvic node dissection. Pathology showed a 3.8 cm invasive endocervical adenocarcinoma with deep stromal invasion and negative nodes. She received post op radiation and chemotherapy. At last contact, the patient was doing well.

The OB/GYN received a notice of claim alleging a delay in diagnosis.

The claim was mediated and settled for $145,000.

In September 2014, a 70-year-old lady presented to the ED with epigastric and right flank pain along with nausea and vomiting. CT abdomen revealed "a 3.3 cm hypodense liver mass." The ED physician referred the patient back to her PCP for follow up and additional workup. A month later the patient returned to her PCP with complaints of constipation and abdominal pain. The PCP documented the report of the liver lesion and that follow up was required. A chest x-ray and laxative were ordered. Over the next several months, the patient saw the PCP on numerous occasions with complaints of pain. No additional mention of the liver lesion was ever made, and no follow up studies were ordered. She was referred to a pain specialist in March 2015.

A month later, the patient presented to the ED with right flank and chest pain. CT revealed a large soft tissue mass involving the liver, pleura, and ribs. The patient was admitted to the hospital, and biopsy of the mass revealed adenocarcinoma compatible with hepatobiliary origin. She went out of state for treatment with chemotherapy and radiation and died in January 2016.

A notice of claim was filed for delay in diagnosis.

The claim was settled at mediation for $195,000.

These cases are just two examples of failure to diagnose which, along with delay in diagnoses, is one of the most common reasons that patients file claims against physicians. In both cases, as in most other failure to diagnose claims, there is a good chance they could have been prevented and serious consequences avoided if proper processes were in place.

A failure to communicate a test result is one of the leading causes of failure to diagnose. Not communicating a normal test result to a patient may be of no consequence, but failure to notify a patient of a potential malignancy or a delay in notification can result in a cancer that is no longer in its earliest, most treatable stage and can lead to a devastating outcome.

In the cases reported, the delay was caused by the physician misinterpreting the report or not ordering follow up studies. In other instances, the failure may be that the physician never received the report, the results were not communicated to the patient, or the patient failed to return for follow up. But whatever the cause, processes should be in place to avoid a failure in communication that leads to a missed or delayed diagnosis.

How should a patient be notified of test results? It had been quite common for patients to be told "no news is good news". But then when the phone call came to make an appointment to see the physician for the results, every patient knew the doctor was not going to deliver good news. Even if the news is not good, many patients prefer a timely call from the physician to tell them the results so that questions can be asked and a plan can be initiated.

Now, many hospitals and physician offices use a patient portal to deliver results. In this electronic and fast-moving age, younger patients would rather be notified of results via a portal. But is this really the best way? A friend of mine would many times go to his portal for this CT results, only to find that his cancer had worsened. He then had to wait several long days for the physician to call and discuss the implications of the not so good results. I recently went for a study and was told to wait in the dressing room for my results. Before anyone came back into my room, I had received the report on my phone via the portal. The result was normal, but how would I have felt if I had received a disturbing report on my phone?

Whatever mechanism of communication of test results is used, please be sure to do the following:

- Educate the patient about what test is ordered, why the test is ordered, and when and how the results will be delivered.
- Have a process in place to ensure that every result (normal or abnormal) is communicated to the patient.
- Avoid the "no news is good news" policy.
- Instruct the patient that if results are not received by a certain date to call for results and who to call.
- Document in the medical record the test results that were discussed with the patient and the instructions for follow up.
- Make sure the patient returns for any follow up studies, office visits, or referrals to other physicians.

ROBERT S. CALDWELL, M.D. AWARD

Dr. Purcell came to UMMC from New York after completing his medical education at Wright State University Boonshoft School of Medicine. Dr. Matt Graves, his program director had a few words to say about him. "Dr. Purcell is a lifelong learner, and he will give as much as you give him and is always thankful for whatever amount that is. He has the ability to provide empathetic care to patients, seeing them as human beings and not just the procedure. He volunteers his time to numerous organizations in the community and outside of it. This is the type of caring physician we should all want for our families and ourselves. "

Since 1982, MACM has recognized the top resident at the University of Mississippi Medical Center with the Robert S. Caldwell, MD Award given each year in memory of the late Dr. Caldwell, a general surgeon from Tupelo who was instrumental in the founding of MACM. Dr. Caldwell served on MACM's first Board of Directors and was elected the Company's first secretary. This award is presented every year in recognition of excellence in medical care, record keeping, patient relations and leadership.

This year the award was given to Dr. Kevin Purcell, Orthopaedics.

From left to right: Dr. Houston, Dr. Purcell, Dr. McVey

HOME GROWN: MISSISSIPPI'S VERSION OF MEDICAL MARIJUANA

By: Kathy Stone, BSN, RN
Vice President of Risk Management

Stephanie Edgar, J.D.
General Counsel

On February 2, 2022, Governor Reeves signed SB 2095, the Mississippi Medical Cannabis Act, into law. Mississippi now joins thirty-seven other states and four territories that permit the use of medical marijuana. At the federal level, cannabis remains illegal and is classified, along with heroin and cocaine, as a Schedule I drug, signifying a high potential for abuse with little to no medical benefit. Regardless, medical marijuana is now a reality in the Magnolia State. Physicians, certified nurse practitioners, physician assistants, and optometrists licensed in Mississippi are free to, but are not required to, certify certain patients for the use of medical cannabis, provided they are approved to do so by the Mississippi Department of Health (MSDH). Bear in mind that the Mississippi Board of Medical Licensure has drafted its own regulations pertaining to medical marijuana as well.

Provider Registration

All providers must apply with the MSDH to become registered for written certifications. In the first year, the MSDH requires eight hours of continuing education in medical cannabis. After the first year, only five hours will be required.

Patient Eligibility

Under state law, providers do not prescribe medical cannabis. The reason for this is that it is illegal under federal law for healthcare providers to prescribe medical marijuana. Rather, they are permitted only to certify a select group of patients for its use. The dispensaries are then charged with determining the correct dosages within the parameters of the law. In order to be eligible for certification, a patient must have one of the following conditions: chronic pain that is unresponsive to other treatments despite reasonable efforts by a practitioner; cancer; Parkinson's disease; Huntington's disease; muscular dystrophy; glaucoma; spastic quadriplegia; HIV; AIDS; hepatitis; ALS; Crohn's disease; ulcerative colitis; sickle-cell anemia; Alzheimer's disease; agitation of dementia; PTSD; autism; pain refractory to appropriate opioid management; diabetic/peripheral neuropathy; spinal cord disease or severe injury; or a chronic, terminal or debilitating disease or condition or its treatment that produces cachexia or wasting syndrome, chronic pain, severe or intractable nausea, seizures, or severe and persistent muscle spasms such as that seen with multiple sclerosis. Additional conditions may be added to this list via petition and will be approved at the MSDH's discretion.

Patient Certification

Before a provider can certify an eligible patient, there must be a **practitioner-patient relationship** during which the provider has completed an **in-person assessment** of the patient's

IN ORDER TO BE ELIGIBLE FOR CERTIFICATION, A PATIENT MUST HAVE ONE OF THE FOLLOWING CONDITIONS:

- *Chronic pain that is unresponsive to other treatments despite reasonable efforts by a practitioner*
- *Cancer*
- *Parkinson's disease*
- *Huntington's disease*
- *Muscular dystrophy*
- *Glaucoma*
- *Spastic quadriplegia*
- *HIV*
- *AIDS*
- *Hepatitis*
- *ALS*
- *Crohn's disease*
- *Ulcerative colitis*
- *Sickle-cell anemia*
- *Alzheimer's disease*
- *Agitation of dementia*
- *PTSD*
- *Autism*
- *Pain refractory to appropriate opioid management*
- *Diabetic/peripheral neuropathy*
- *Spinal cord disease or severe injury*
- *A chronic, terminal or debilitating disease or condition or its treatment that produces cachexia or wasting syndrome, chronic pain, severe or intractable nausea, seizures, or severe and persistent muscle spasms such as that seen with multiple sclerosis.*

medical history, current mental health, and medical condition. The provider is also required to **document** his or her certification in the patient's chart. The patient is required to **follow up** with the certifying provider at six months. Actual certification is made on a form approved by the MSDH and must be signed and dated by the provider, certifying that a patient has one of the conditions listed above. The form must also include the following: date of issue and effective date of recommendation; patient's name, date of birth and address; practitioner's name, address and DEA number; and the provider's signature. Further, the provider shall affirm that certification was made in the course of a bona fide practitioner-patient relationship. Certifications remain valid for twelve months unless the provider specifies a shorter time period. If, at any point during the certification period, the provider notifies the MSDH in writing that the patient has ceased to have a debilitating medical condition or that the provider no longer believes that the patient would receive medical or palliative benefit from the use of medical cannabis, the certification is nullified.

Minors

Only M.D.s and D.Os may certify that minors, those under the age of eighteen, are eligible for the use of medical cannabis. In addition, the physician must explain the potential risks and benefits of medical marijuana to the minor's custodial parent or legal guardian. The custodial parent or legal guardian must then consent, in writing, to the following: acknowledgment of the potential harms related to the use; allowance for the qualifying patient's medical use; service as the qualifying patient's designated caregiver; and control of the acquisition of the medical cannabis as well as the dosage and frequency of the use of medical cannabis by the patient.

18- to 25-year-olds

Patients between the ages of eighteen and twenty-five are not eligible for a medical cannabis registry identification card unless two providers from separate medical practices have diagnosed the patient with a debilitating medical condition after an **in-person** consultation. One of these providers must be an M.D. or D.O. If one of the recommending providers is not the patient's primary care provider, that provider shall review the records of the diagnosing provider. The two providers must be from separate medical practices unless the patient is homebound or the patient had a registry identification card before the age of eighteen.

What Could Possibly Go Wrong?

Even before passage of the Mississippi Medical Cannabis Act, we were getting regular calls from a variety of physicians with urgent questions about patients or parents of patients that were obviously impaired at the time of visits. For example, a patient showed up for a surgical procedure and admitted to having smoked marijuana that morning. The surgeon was understandably concerned about getting adequate consent as well as potential anesthesia and medication interactions. We advised the surgeon to reschedule the procedure and inform the patient to abstain from marijuana prior to the procedure. However, it would be best for physicians to develop a policy to address this issue before the need arises. Ideally, the policy should address chronic marijuana users and the potential risk of withdrawal during a procedure or the post-operative period. A one-size-fits-all approach may not be the best one. And it is now imperative for physicians and their staff to obtain a clear history of marijuana use, just as they would the patients' medication histories.

At the other end of the spectrum, pediatricians regularly call with concerns that parents or caregivers are impaired and smell of marijuana when they bring a child to a visit. We have advised these physicians to alert local law enforcement prior to the patient leaving the clinic in order to protect the safety and welfare of the child. Situations like these will only increase with the use of medical marijuana. Whether you fall into the camp of believing that marijuana has a medicinal effect or not, you should be aware that many of your patients may be availing themselves of it, which will necessitate your analysis of how that will impact your care and treatment of these patients.

Presently, there is no right to a third-party action for medical malpractice in Mississippi, although these types of claims are on the rise across the country. For example, if you prescribe opioids to a patient who then injures or kills another in a car accident while under the influence of the opioids you prescribed, you are not liable to the injured party for medical malpractice in Mississippi. However, the data shows that in Colorado, Washington, and Oregon, all states that legalized the *recreational* use of marijuana, injury crash rates have risen from four percent to eighteen percent since legalization. Consequently, it will be imperative that you adequately warn your patients about the risks if you intend to certify them for the use of medical cannabis. Further, all of these warnings need to be memorialized in writing in the chart and in a consent that patients (or their guardians), of all ages, will be expected to sign.

MACM's Response to Medical Marijuana

MACM will insure its providers to certify patients for medical marijuana provided the certification is done under lawful circumstances and in accordance with risk management recommendations. In addition, several questions will be added to our original and renewal applications to determine who, among our insureds, is certifying patients and at what volume. These questions are also designed to determine the age ranges of those patients that are certified. Further, we will be asking whether an insured is certified personally for the use of medical marijuana. If you are certifying patients for the use of medical marijuana, we will first verify that you have met the requirements for MSDH registration. Then, personnel from our Risk Management Department will contact you to offer education and advice and to confirm that you are following the Mississippi Board of Medical Licensure's regulations. Coverage will be contingent upon the Risk Management Department's review of your certification process. If you are personally certified to use medical marijuana, you will be invited to meet with the Risk Management Committee. If, at the time you complete your renewal application, you are not certifying patients but during the policy year, you decide to do so, you must contact MACM.

By all accounts, medical marijuana will not become much of a reality in Mississippi until the latter part of 2022. But rest assured that MACM is here to educate and protect you.

ONLINE POLICY
RENEWAL UPDATE!

We are excited to inform you that Medical Assurance Company of Mississippi (MACM) will store all policy documents within its Members Only portal beginning with the upcoming 2023 policy year.

As in previous years, you will receive an email from MACM in September asking you to log in to Members Only (email and password) and complete and submit your Renewal Application. If approved, your policy will be renewed and subsequently made available to you, along with the Premium Notice, on the Members Only portal the first week of December. Of course, if the Renewal Application has not been submitted by then, the policy and Premium Notice will not be available.

Please note that if you pay by check, you will need to log in to Members Only in order to retrieve your Premium Notice to determine the premium you must submit. If you would like to convert to the electronic bank draft method (monthly or annual), you may request to do so at any time by contacting us for a Bank Draft Authorization form. For insureds already on bank draft, you will be able to view the amount to be drafted by clicking on the Premium Notice.

Policy documents will not be mailed to you unless you contact us and request a paper copy.

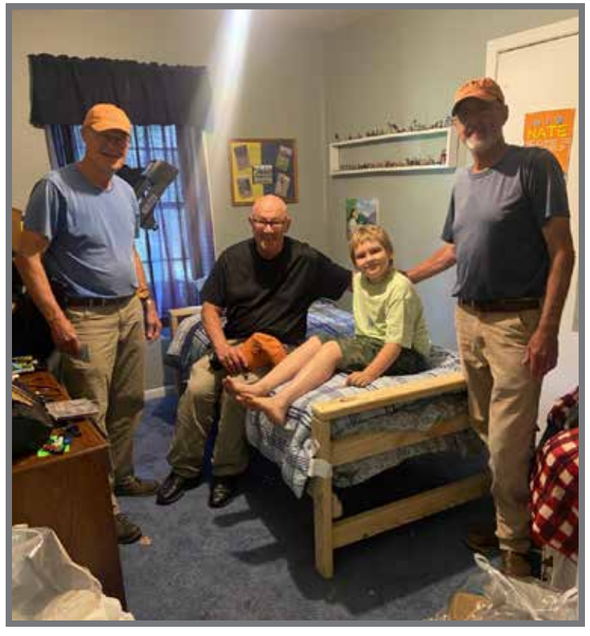
Thank you in advance for allowing us this opportunity to better serve you. If you have any questions, please contact the Underwriting Department by calling (800) 325-4172.

SPOTLIGHTING OUR PHYSICIANS

BEDS FOR KIDS

By: Kim Mathis
Director of Marketing

MACM Physicians in the community do so much more than practice medicine. When I started my interview with Cardiologist, Dr. Michael Boland, about Beds for Kids, the intent was to highlight how he gives back to his community. However, I quickly learned that Dr. Boland is not the only physician involved in this organization. Cardiologist, Dr. Jack Foster, and Cardiovascular Surgeon, Dr. Max Hutchinson are also involved. These three MACM physicians are giving back to their community and positively impacting the children they are helping. Beds for Kids is a not for profit associated with First Methodist Church of Tupelo. Several men at First Methodist had worked with Habitat for Humanity for some time and were looking for other ways to serve the community. Their original goal for Beds for Kids was to provide 100 beds a year. They had no idea that the organization would be making and providing over 1000 beds each year by the third year. A group of volunteers, including Dr.'s Boland, Foster and Hutchinson spend their Wednesdays and Thursdays in an old warehouse making twin size bed frames that will eventually end up going to a child in need of a bed. This might be the first bed for many of these kids. Money is raised to help purchase mattresses and bedding and donations are collected from local businesses. Once they get "the call" that a child needs a bed, the organization will take the twin bed frame, mattress, bedding, and supplies, including a stuffed animal and an age-appropriate Bible to the child in need. The group then sets up the bed and prays over the bed. Over 90 percent of the beds given away are within 5 miles of the Tupelo area; however, they do provide beds all the way to a local church in Philadelphia, 20 beds a month to a church in Marks, MS, and beds to kids near the Tennessee line. This work could not be done without the generosity of the community and First Methodist Church of Tupelo. These three MACM physicians have taken care of patients needs for many years. They are now touching the hearts of many through Beds for Kids.



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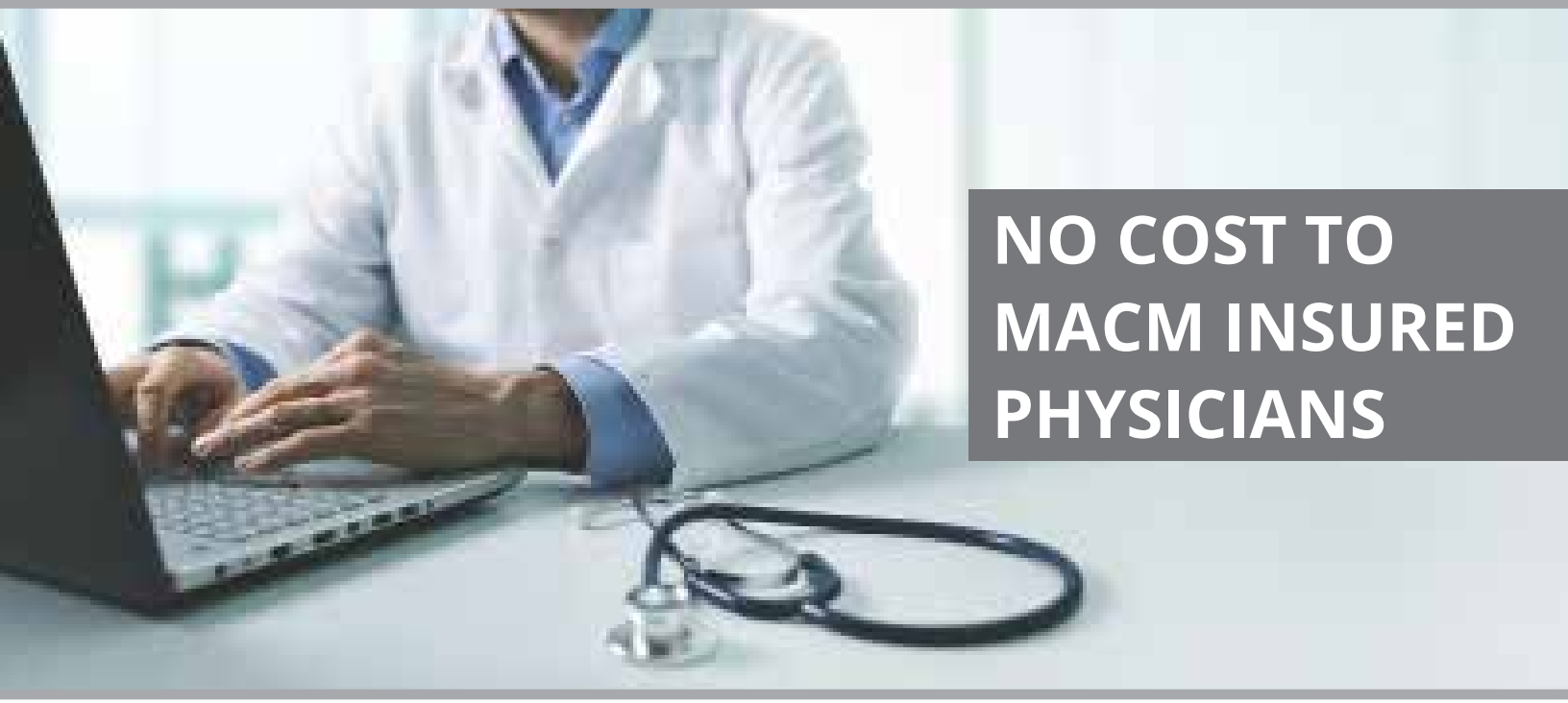

MEDICAL INTERACTIVE

OVER 200 FREE ONLINE CME COURSES NOW AVAILABLE TO PHYSICIANS

MACM is working with Medical Interactive, a national provider of risk management and patient safety education, to provide our physician insureds access to free online CME and MOC credits. Medical Interactive has a series of courses that meet the requirements of Mississippi's five hours for prescribing controlled substance education. The Medical Interactive CME courses have been approved by 17 medical boards for MOC points. Please sign in to the "Member Login" section of the website for more details.